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Insurer Cost and Utilization Measures
Report Deadline: March 31, 2015
Guidance

Introduction

Montana insurers with PCMH contracts are required by Patient-Centered Medical Home Act (Act), Mont. Code Ann. § 33-1-101 to report on compliance with the adopted uniform set of cost and utilization measures. According to ARM 6.6.4906, the first annual report from PCMH payors is due to the Montana Office of the Commissioner of Securities and Insurance (CSI) on March 31, 2015.

Payors must submit data from calendar year 2014 on two utilization measures: ER visits and hospitalizations. The prescribed method for measuring and reporting described below is required, but the proposed attribution method is not. Flexibility is allowed for attribution methods. Payors that do not have an attributed PCMH population will report these metrics for their entire population.

Method for measuring and reporting the required utilization metrics:

1. **Method for measuring and reporting of Emergency Room Visits (ER Visits per 1,000*)**

ER Visits per 1,000 is the average number of emergency room facility visits provided under medical coverage, per 1,000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations (ER Visits/(Member Months/1000))*12.

Additionally:
If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the entire payor's fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

2. **Method for measuring and reporting of Hospitalization Rates (Admits per 1,000*)**

Admits per 1,000 is the average number of acute admissions per 1,000 members with medical coverage per year (Admits/(Members Months/1000))*12.

Additionally:
If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the entire payor's fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

Proposed Attribution Method:

1) PCMH is established when an approved entity notifies payor of their intent to participate, and signs an agreed upon contract.
2) PCMH sends payor list of participating providers **practicing** as Primary Care within the following specialty categories.
    a. Family Practice
    b. Internal Medicine
    c. Internal Medicine w/ subspecialty of Endocrinology (for diabetic patients)
    d. Pediatrics
    e. OB/GYNs
    f. General Practice
    g. Nurse Practitioners and Physician Assistants practicing in one of the above specialties
3) Member eligibility is established based on active payor membership for the specified time period & exclusion of certain lines of business
4) Member qualification for participation in PCMH
    a. Member- Provider relationship established using 2-year retrospective payor claims utilization (provider type, volume, and frequency of visits)
5) PCMH and payor repeat the above process on a monthly basis to set agreed upon provider and patient panel for reporting and compensation purposes.

Please Note: This is one proposed attribution method. Payors may develop other attribution methods, ***for approval by the commissioner.***